

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 06/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The following citations represent the findings of a Health Resurvey.</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This Requirement is not met as evidenced by: The facility had a census of 31 residents, with 13 residents selected for sample. The sample included review of choices for 3 residents.</p> <p>Based on observation, interview and record review, the facility failed to offer 1 of 3 residents the right to make choices related to aspects of their lives that were significant to them (choices related to time of awakening in the morning). (Residents #5)</p> <p>Findings included:</p> <p>- Resident #5's clinical record included a 5/8/14 Annual MDS (Minimum Data Set) that identified the resident with no cognitive impairment and the required extensive assistance of two staff members for bed mobility and dressing. The resident was totally dependent for transfers and did not ambulate. Locomotion was provided with assistance from one staff member.</p> <p>Care Area Assessment summaries completed after the 5/9/14 MDS lacked any assessments</p>	F 242			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 06/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 242	<p>Continued From page 1 related to resident choices.</p> <p>Resident #5's 10/30/12 care plan indicated the resident had dementia (progressive mental disorder characterized by failing memory, confusion) and made poor decisions. The care plan revealed the resident requested his/her time to be out of bed to coincide with important activities to him/her. The care plan lacked any interventions related to the resident's choice of time to awaken.</p> <p>Review of the clinical record from the date of admission (Social Services notes, Nurses Notes, and previous care plans) lacked evidence the facility asked about resident #5's preferences related to time of awakening in the morning.</p> <p>During an observation on 6/5/14 at 7:30 a.m., a direct care staff person pushed the resident down the hallway in his/her wheelchair for breakfast.</p> <p>During an interview on 6/3/14 at 2:33 p.m., Resident #5 denied the ability to make choices related to his/her preferences for awakening in the mornings. According to the resident, he/she preferred to sleep "in" most mornings, but staff usually awakened him/her at 7:00 a.m. by knocking, then entered and spoke with him/her about getting up.</p> <p>During an interview on 6/10/14 at 1:15 p.m. direct care staff G stated the staff entered the room at approximately 7:00 a.m. and woke the resident up gently if he/she was not awake and asked him/her if he/she was ready get up. Staff G added this process was not a care planned intervention.</p> <p>During an interview on 6/10/14 1:27 p.m. licensed nursing staff F stated the resident expressed a</p>	F 242			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 06/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 242	Continued From page 2 desire to sleep in, in the past. Staff F explained the aides knocked on the resident door and would inform him/her it was about breakfast time and asked if he/she wanted to get up and dressed. The facility's undated PATIENT/RESIDENT RIGHTS policy revealed under the heading "Right to Make Care Decisions", the resident had the right of free choice related to developing an individual plan of care. The facility failed to allow resident #5 the right to choose the time he/she awakened each morning.	F 242			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 31 residents with two units, a Special Care Unit and the main nursing unit. The facility identified 1 resident on the main nursing unit as independently mobile with cognitive impairment. Based on observation, interview, and record review, the facility failed to ensure the resident environment on the main nursing unit remained free of accidents/hazards (chemicals accessible to residents) for 1 independently mobile resident with cognitive impairment. Findings included:	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 06/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 3 - During an initial tour of the facility on 6/3/14 at 8:35 a.m., the unlocked soiled utility room on the main nursing unit contained an unlocked cabinet that had a sign directing staff to keep the cabinet locked. The unlocked cabinet contained the following hazardous chemicals: * One gallon of Endozime Enzymatic detergent, labeled "Caution: Avoid prolonged contact with skin. Do not swallow, keep away from children, discard after use." * One 64 ounce container of Novus Plastic Polish, labeled "Inhalation: Move victim to fresh air. Skin: Remove contaminated clothing, wash skin thoroughly with soap and water. Eyes: Immediately flush eyes with large amounts of water for at least 15 minutes while holding the eyelids open. Get prompt medical attention. Ingestion: Contact local poison control center or physician immediately." An interview on 6/3/14 at 8:50 a.m. with licensed nurse F revealed the cabinet should be locked. Nurse F then locked the chemicals in the cabinet in the soiled utility room. On 6/11/14 at 9:30 a.m., licensed nurse D identified one resident on the main nursing unit as independently mobile with cognitive impairment. Although requested, the facility failed to provide a policy related to chemical storage. The facility failed to ensure hazardous chemicals remained secured and inaccessible to one independently mobile resident.	F 323			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 06/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 4</p> <p>unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This Requirement is not met as evidenced by: The facility had a census of 31 residents with 5 residents reviewed for unnecessary medications.</p> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 5 sampled residents did not receive unnecessary medications (failure to adequately monitor for potential adverse reactions related to the use of hormone replacement therapy). (#6)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #6's 5/14/14 physician order sheet included a diagnosis of menopausal symptoms. 	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 06/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 5</p> <p>The order sheet also included an order for Premarin (estrogen supplement) 0.3 mg (milligrams) daily for hormone replacement therapy with a start date of 3/8/13.</p> <p>Resident #6's annual MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 13 which indicated intact cognition. According to the assessment the resident received antipsychotic and antidepressant medications for 7 days of the assessment period.</p> <p>Resident #6's 3/24/14 cognitive loss CAA (care area assessment) summary indicated the resident had occasional negative moods, was alert and able to make his/her needs and wants known.</p> <p>Resident #6's 2/25/14 Medication Management care plan included a boxed warning for the use of Premarin that stated, "warning for endometrial [lining of the uterus] cancer, cardiovascular risks of stroke, deep vein thrombus [blood clot in the legs], myocardial infarction [heart attack], pulmonary emboli [blood clot in the lungs], and invasive breast cancer".</p> <p>According to FDA.com (Food and Drug Administration website), contraindications for the use of Premarin included known, suspected, or history of breast cancer. The label for Premarin included the following patient information: All women should receive yearly breast examinations by a health care provider and recommended annual breast examinations and mammography (X-ray of the breasts), unless otherwise directed by the health care provider.</p> <p>Review of resident #6's clinical record revealed</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 06/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 6 lack of evidence of a mammogram since admission to the facility on 3/8/13. During an observation on 6/9/14 at 3:10 p.m., resident #6 sat in a recliner as direct care staff H assisted the resident with range of motion exercises. The resident was pleasant and cooperative during the interaction. An interview on 6/10/14 at 10:20 a.m. with licensed nurse D confirmed resident #6's clinical record lacked evidence of a mammogram and stated he/she checked with the resident. The resident told nurse D that his/her last mammogram was about 9 years ago and he/she would like to have one done. The facility failed to adequately monitor for potential adverse reactions related to the use of Premarin, a hormone replacement medication for resident #6 whose last mammogram was 9 years ago.	F 329			
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This Requirement is not met as evidenced by: The facility had a census of 31 residents. Based on observation, interview and record review, the facility failed to properly contain garbage and refuse in containers with lids/coverings. Findings included: - During an observation on 6/3/14 at 5:25 p.m.,	F 372			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 06/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 372	<p>Continued From page 7</p> <p>four large "dumpster" type garbage containers with double sided lids stood in an area directly north of the facility. One dumpster had one of two lids opened.</p> <p>An observation on 6/4/14 at 7:30 p.m. revealed four dumpsters which contained garbage/refuse and not fully covered with lids or other coverings.</p> <p>An observation on 6/4/14 at 1:10 p.m. revealed four empty dumpsters with 1 dumpster lid open.</p> <p>An observation on 6/5/14 at 7:30 a.m. revealed four dumpsters with 1 dumpster lid open.</p> <p>During an interview on 6/10/14 at 5:25 p.m., licensed nursing staff D acknowledged the dumpster lids should remain closed and staff who place garbage in the dumpsters should close the lids afterwards.</p> <p>Although requested on 6/10/14 at 5:30 p.m., the facility failed to provide a policy related to storage of garbage/refuse.</p> <p>The facility failed to properly contain garbage and refuse in containers with lids/coverings when they placed garbage/refuse in dumpsters with missing lids or lids left open.</p>	F 372			
F 428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p>	F 428			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 06/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 428	<p>Continued From page 8</p> <p>This Requirement is not met as evidenced by: The facility had a census of 31 residents with 5 residents reviewed for unnecessary medications.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the consultant pharmacist identified drug irregularities and reported them to the director of nursing and attending physician for 1 of 5 residents reviewed for unnecessary medications (failure to adequately monitor for potential adverse reactions related to the use of hormone replacement therapy). (#6)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #6's 5/14/14 physician order sheet included a diagnosis of menopausal symptoms. The order sheet also included an order for Premarin (estrogen supplement) 0.3 mg (milligrams) daily for hormone replacement therapy with a start date of 3/8/13. <p>Resident #6's annual MDS (minimum data set) assessment revealed the resident had a BIMS (brief interview for mental status) score of 13 which indicated intact cognition. According to the assessment the resident received antipsychotic and antidepressant medications for 7 days of the assessment period.</p> <p>Resident #6's 3/24/14 cognitive loss CAA (care area assessment) summary indicated the resident had occasional negative moods, was alert and able to make his/her needs and wants known.</p>	F 428			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 06/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 428	<p>Continued From page 9</p> <p>The updated 11/6/13 nursing care plan for resident #6 directed staff to not argue with the resident as it only agitated him/her.</p> <p>Resident #6's 2/25/14 Medication Management care plan included a boxed warning for the use of Premarin that stated, "warning for endometrial [lining of the uterus] cancer, cardiovascular risks of stroke, deep vein thrombus [blood clot in the legs], myocardial infarction [heart attack], pulmonary emboli[blood clot in the lungs], and invasive breast cancer".</p> <p>According to FDA.com (Food and Drug Administration website), contraindications for the use of Premarin included known, suspected, or history of breast cancer. The label for Premarin included the following patient information: All women should receive yearly breast examinations by a health care provider and recommended annual breast examinations and mammography (X-ray of the breasts), unless otherwise directed by the health care provider.</p> <p>Review of resident #6's clinical record revealed lack of evidence of a mammogram since admission to the facility on 3/8/13.</p> <p>Review of resident #6's monthly drug regimen 7/2/13 - 5/5/14 revealed no irregularities related to the use of hormone replacement therapy.</p> <p>During an observation on 6/9/14 at 3:10 p.m., resident #6 sat in a recliner as direct care staff H assisted the resident with range of motion exercises. The resident was pleasant and cooperative during the interaction.</p> <p>An interview on 6/10/14 at 10:20 a.m. with</p>	F 428			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 06/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER KEARNY COUNTY HOSPITAL LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 607 COURT PL LAKIN, KS 67860		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 428	<p>Continued From page 10</p> <p>licensed nurse D confirmed resident #6's clinical record lacked evidence of a mammogram and stated he/she checked with the resident. The resident told nurse D that his/her last mammogram was about 9 years ago and he/she would like to have one done.</p> <p>Attempts to reach consultant pharmacist J on 6/10/14 at 5:06 p.m. and 6/11/14 at 10:49 a.m. were unsuccessful.</p> <p>The facility failed to ensure the consultant pharmacist identified irregularities related to the use of hormone replacement therapy for resident #6.</p>	F 428			